The art of engagement

Philadelphia's recovery-oriented service transformation drives lasting changes

BY DENNIS GRANTHAM, EDITOR-IN-CHIEF

There's a reason why efforts to replace a traditional system of behavioral healthcare with a recovery oriented system of care (ROSC) is referred to as a "transformation." It is because organizations large or small involved in such an effort face an all-encompassing challenge. And, it's a challenge that they cannot meet by themselves.

Almost nine years ago, the appointment of psychologist Arthur Evans Jr., Ph.D., as Commissioner of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) marked the start of a huge effort. In time, the effort would touch every aspect of a system that today has a $1.2 billion service budget, encompasses more than 200 provider organizations, and has a responsibility to more than a half-million Philadelphians—over 140,000 of whom receive behavioral health services annually.

So, how did Commissioner Evans and the DBHIDS team go about making a transformation to ROSC based on core principles of recovery, resiliency, and self-determination "real"? *Behavioral Healthcare* went to Philadelphia, met with Commissioner Evans and his team, and took a first-hand look.

First steps

The key to a successful evolution to ROSC, said Evans, "is engagement. Being a payer is easy," he added, "but administering a recovery focused system is different. How do we insure that the most people in our system have a chance for recovery?" The only way, in a ROSC, is to create opportunities for people to engage individually with the prospect of change, to feel the pull of hope in recovery, to act on this hope with the help of DBHIDS resources, and to sustain recovery with the help of an understanding and supportive community.

Arthur Evans Jr., Ph.D., Commissioner of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), will address participants at the 2013 National Council Conference in April.

The first step in the process was a recognition: Outcomes would no longer be the sole responsibility of professionals, but a shared responsibility between professionals and newly engaged and empowered service recipients, families, providers and organizations, neighborhoods and others.

At the outset, to bring these stakeholders into the process, DBHIDS launched a new workgroup that combined not only professionals but many community stakeholders, to define key principles of the new recovery-focused transformation effort. This group defined recovery and selected core recovery values for Philadelphia's transformation effort:

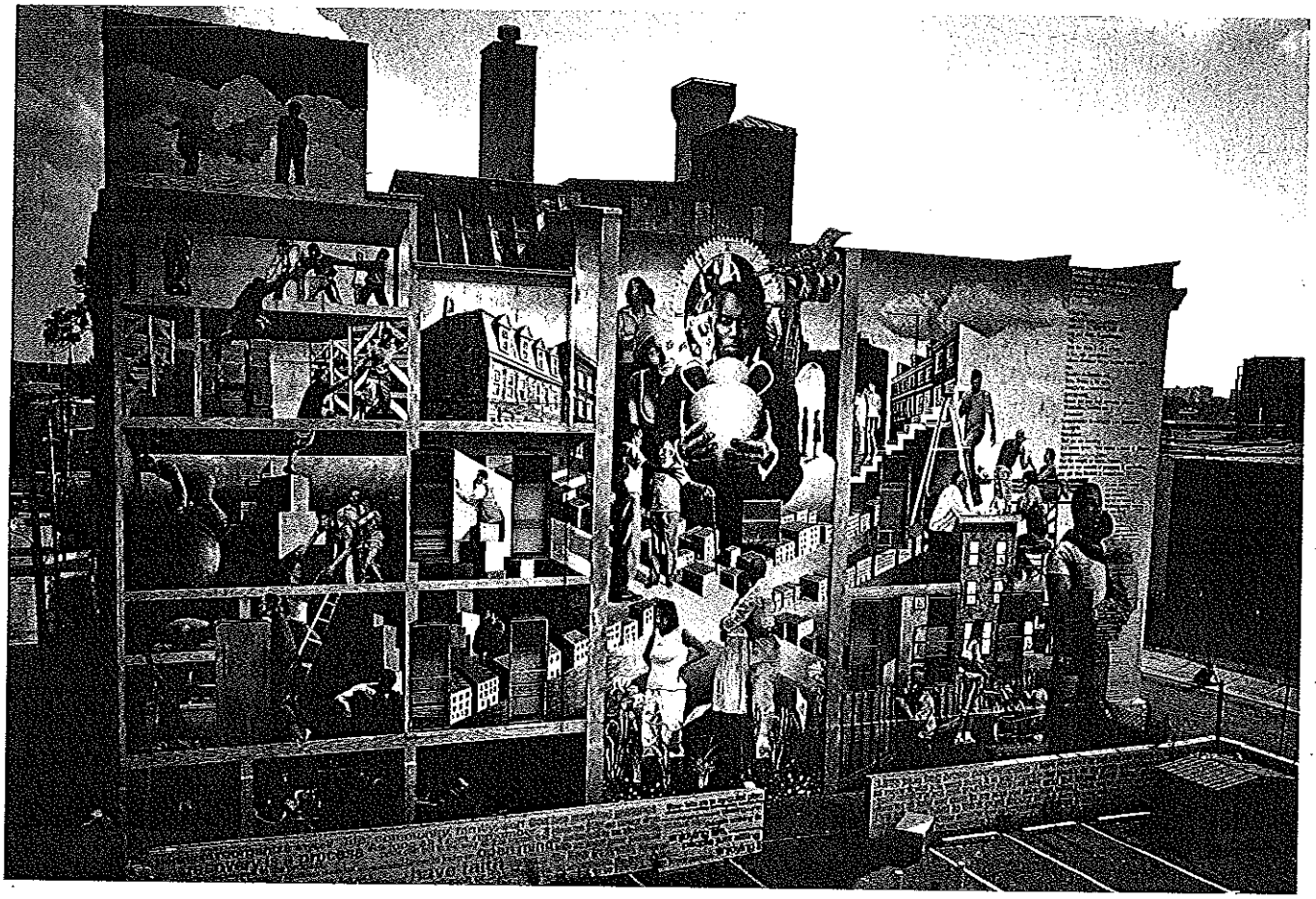
- Hope
- Choice
- Self direction/empowerment
- Peer culture/support/leadership
- Partnership
- Community inclusion/opportunities
- Spirituality
- Family inclusion and leadership
- Holistic/wellness approach

The transformation process itself, Evans explained, was shaped through ongoing focus on three variables: [1]

- How do we want thinking (concepts and ideas) to change?
- How do we want behavior (work processes, relationships) to change?
- How do we want the overall context (fiscal, policy, administration) to change?

Many approaches build behavioral health literacy, community support

- **Crisis Intervention Training (CIT):** 1,600 officers trained to date.
- **Mental Health First Aid training:** District Attorney's office, Public Defender's office, local courts, child welfare officers, community and faith leaders. Ongoing MHFA classes are open to the public.
- **Specialized and gender-specific programs:** Men, women, trauma victims, LGBT, youth, homeless.
- **Mobile crisis intervention teams**
- **Community dialogues:** Outreach efforts to understand the needs of neighborhoods, ethnic, spiritual, or cultural groups. These often uncover specific needs and lead to better engagement with services.
- **Faith-based outreach:** Dialogue and education enlist the help of faith leaders and local congregations in embracing those seeking recovery.
- **Embedded supports:** Peer-led recovery centers and resources are embedded in the culture and fabric of city neighborhoods.



In recent years, the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) has partnered with Philadelphia's world-renowned Mural Arts program to encourage understanding and unite local citizens around important issues in behavioral health. In one neighborhood, when the expansion of a methadone clinic sparked concern, DBHIDS joined with the Mural Arts program to sponsor a community dialogue. The result was the development of a five-story mural, *Personal Renaissance*, which adorns the side of the JEVS Human Services facility at 1745 N. 4th St. The mural not only captures the very human stories that typify the journey to recovery, but also symbolizes the community's understanding and support for the ongoing work of treatment. (*Personal Renaissance* © 2010 City of Philadelphia Mural Arts Program. Artist: James Burns. Photo: Mustafah Abdulaziz.)

This focus, practiced at all levels in DBHIDS and provider organizations, helped to drive the ongoing evolution. Changes in concept or philosophy would drive changes in training, practices, and relationships, which would in turn demand adjustments in policies, regulations, funding, or reimbursement. The goal throughout was not only to talk change, but to ensure that current and available tools, processes, and incentives aligned with and encouraged all involved to pursue the path of change.

Walking the talk

The need to demonstrate change wasn't just a provider requirement, but a primary responsibility of DBHIDS leadership, said Evans, who recognized that "the relationship that we want to see between direct-care providers and those they serve must be mirrored inside our department, in the relationships that we have with providers and the community organizations. We had to make sure that we weren't just 'telling them' how to do business, but modeling that behavior as well."

Making and reflecting this big cultural shift within DBHIDS—from a traditional role as payer and policeman of vendors to a new role as a supporter and collaborator—was essential to building collaborative relationships and convincing providers that transformation was real.

Establishing and sustaining a tone of dignity, respect, and inclusion was essential to the system-wide effort to tap into the needs, expertise, and abilities of all. Within DBHIDS, it necessitated creation of additional strategic planning resources and a new Systems Transformation Steering group. The group's task was to prioritize key programs for transformation, then with the help of other work groups and task forces, re-envision what the transformed programs would look like and how to implement them.

A provider's eye view

From the outset, providers heard Evans "talk of a new role—the role of the peer—and of a new relationship with the consumer. Going forward, services would be shaped around consumer wants, needs, and outcomes," recalled William Dinwiddie, CEO of the Mental Health Association of Southeastern Pennsylvania (MHASP). "All of this came as quite a surprise to the professionals that

surrounded me. After decades of being recognized as the experts in treatment, this was a new variable."

On hearing Evans' plans, providers asked, "'If we're going to change the programs, then where's the money?'" said Dinwiddie. "But Arthur's message was, 'There isn't any new money. There isn't any rule book to follow.' He said, 'If you want to be a provider long-term, you have to reorient your organization. You have to figure this out.'

"No one told us exactly what we had to do," Dinwiddie remembered, explaining that conventional wisdom among providers was to "start small" and build on success. This experimental approach led providers to reach out to DBHIDS and to each other, across traditional boundaries and lines of service to talk about what they were learning.

"So," Dinwiddie said, "the first tentative steps began—changes to waiting rooms, assessments, intake procedures." There was also a move away from getting consumer input in occasional focus. More and more organizations chartered, created, and empowered new consumer advisory councils. Over time, these self-governing, responsibility-taking, peer-led groups develop an increasingly articulate and co-equal voice with that of the professionals.

Peer training and leadership

To equip peers with the skills needed to serve each other, a training program was formed with a local college to develop certified peer support and certified recovery support specialists. Then, to build on that, two organizations, PRO-ACT (Pennsylvania Recovery Organization- Achieving Community Together), and MHASP teamed up to create a "Peer Leadership Academy." This curriculum would challenge some peers to apply new skills and knowledge in leadership roles.

Today, both peer specialists and peer leaders are part of the fabric at organizations throughout the city. Among these are four Recovery Community Centers (RCCs) operated by PRO-ACT. These peer-led centers offer recovery-sustaining resources to people in recovery and their families, along with hundreds of skill-building workshops and support programs each month.

Before and after: Issues in service transformation[2]

Issue	"Old system" of care	Recovery-oriented system of care (ROSC)
Role, Person in Recovery	Service recipient	Service co-planner and participant
Service relationship	Expert to patient	Consultant to partner
Assessment	Pathology based, infrequent	Strengths based, continuous
Treatment approach	Clinical care is primary	Many-faceted: clinical, natural, community supports
Retention	High dropout rates	Higher retention and completion rates
Service location	Facility based	Locally embedded resources, supports
Peer-based services	None	Many
Dose-duration of services	Long-term, maintenance level treatment	High-intensity at outset; early intervention if needed
Service goal	Acute stabilization and maintenance	Sustained recovery and community involvement
Community role	Taxpayers	"Indigenous" recovery-spirituality-advocacy supports

"Given the short duration of current services, the key to promoting recovery is to help people develop post-treatment recovery strategies and resources," said PRO-ACT CEO Beverly Haberle. The RCCs are part of that strategy, serving as recovery sanctuaries and resources, embedded in the culture, the neighborhood, and the community.

New working relationships

Incorporating the needs and voices of people-in-recovery into service processes has had profound effects. Professionals quickly realized that peers had plenty to say, while peers found that their ability to speak up was tempered by new realizations: First, that they now had no one to blame for tolerating treatment that didn't make sense. Second, that to play a meaningful rule, they would be challenged to grow through additional training. Third, that making meaningful contributions to improvement depended in part on their ability to understand and appreciate the knowledge and practices of clinical professionals.

In time, both gained a new appreciation about what consumer insights could do to improve treatment. Joseph Schultz, a longtime substance abuse counselor at Northeast Treatment Centers (NET), a large regional SUD treatment provider, explained that "there were some raised eyebrows when professionals realized that peers were going to review what they had proposed as recovery-focused work processes. What did they know? What could they see that seasoned experts had missed? How could they know what we did better than we did ourselves?"

Schultz said that the review was thorough: "The peer council divided our work proposals, as well as themselves, into a series of small work groups." The peer groups performed "consumer walk-throughs" of the proposed processes, examining clinical procedures and requirements from the patient's point of view. In so doing, peers not only were able to see and understand clinical challenges and requirements, but also to express their own assumptions, questions, and concerns.

Schultz said that what emerged from the reviews were two very important and profitable impacts on services at NET:

1) Peers proposed and obtained resources to develop and operate a resource center, complete with a website and phone lines, that consolidated practical advice, supportive help, and access to dozens of programs and resources for newly recovering individuals. This center provided just the kind of practical help needed by their peers when they stepped outside the treatment setting.
2) Peers identified opportunities when they could serve in lieu of NET professionals. Today, peers conduct consumer outreach, new consumer orientations, offer a friendly voice throughout the treatment process, and provide regular follow-up and supports essential to keeping people-in-recovery connected and successful over the long-term.

Schultz credits the outreach efforts of peers, in particular, for a marked increase in "readiness for treatment" among groups who are served at NET, and higher long-term retention rates. He added that increasing retention rates has a multiplier effect: as professionals serve more people each day, they produce more income and more graduates with the same effort. ■

1,2 White, W. The Recovery-Focused Transformation of an Urban Behavioral Health Care System. Great Lakes Addiction Technology Transfer Center. Accessed at: http://dbhids.org/assets/Forms--Documents/transformation/BillWhite/ACE-GLATTC-interview.pdf